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Towards A Consensus On Continuing Chaos

Claude E. Forget

In this issue...

The Romanow and Kirby reports on the Canadian health-care system fail to provide a basis for lasting reform. In fact, the reports and their findings are destined for the overflowing dustbin of the history of health-care studies in Canada. Fortunately, that does not mean that we have to throw our cherished health-care system itself on the rubbish heap. It does mean that any reconstructive program has to be based on realistic expectations and real-world realities.

The Study in Brief

The findings of the recent Romanow and Kirby reports on reforming the health-care system are doomed to the overflowing dustbin of the history of health-care studies in Canada. Fortunately, that does not mean that we have to throw our cherished national health-care system itself on the rubbish heap. It does mean that any reconstructive program has to be based on realistic expectations and real-world realities. Among them are certain imperatives. Financial accountability requires decision-making power to be co-extensive with fiscal responsibility. Program design must have features that are mutually consistent, including being achievable with allocated resources; if they now lack this consistency, we must redesign them to ensure it. The partnership between the federal and provincial governments has been such a dismal failure that it is time to envisage total devolution. Meanwhile, front-line accountability must go beyond form-filing and embrace true empowerment. Our public universal health system can survive and prosper provided we can overcome the bureaucratic and highly political instincts of its wardens.

The Author of This Issue

Claude E. Forget, a former Quebec health minister, is an independent consultant with a special interest in regulatory affairs, public policy analysis and business strategies in the financial and telecommunications areas.

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Federal-provincial talks about health care and its evolution are underway. The prospect of an agreement is creating a sense of occasion for a variety of reasons: the need for increased funding has been recognized, even in Ottawa; the various study groups, parliamentary committees, and formal commissions of enquiry of recent years have restated problems and outlined recommendations; the documented findings of systemic dysfunctions are fuelling the public's widespread sense that legitimate expectations have increasingly been frustrated and that things have to be put right.

The recent publication of two federal reports has, therefore, led many to suppose that solutions have been found and that now was the time to implement them. These two reports are the Kirby report (Canada 2002c)[1] and the Romanow report (Canada 2002a).[2] Herein I refer to these two documents as "briefs" because they are likely to be used as the briefing books of the federal negotiators.

The purpose of this Commentary is to consider whether those briefs are adequate guides to success. I occasionally refer to a number of provincial briefs, but the essential focus is on the Kirby and Romanow reports.

As much as anyone in Canada, I initially shared the hope that solutions might be in sight, but I am forced to conclude that the reports and their findings are doomed to the overflowing dustbin of the history of health-care studies in Canada.

Fortunately, that conclusion does not mean that we have to throw our cherished national health-care system itself on the rubbish heap. It does mean that any reconstructive program has to be based on realistic expectations and real-world realities. Among them are the following imperatives. Financial accountability requires decisionmaking power to be co-extensive with fiscal responsibility. Program design must have features that are mutually consistent, including being achievable within allocated resources; if they now lack this consistency, they have to be redesigned to ensure it. The nexus of provincial personnel-related policies have to be rethought in a strategic context to reduce the rigidities that block better performance and impede quality enhancement. The partnership between the federal and provincial governments has been such a dismal failure that it is time to envisage total devolution. Front-line accountability must go beyond form-filing and embrace true empowerment. All these building blocks could provide a measure of hope for the future. It is not true that we have exhausted every possibility. Our public universal health system can survive and prosper provided we can overcome the bureaucratic and highly political instincts of its wardens.

It is not just that the existing — even more, the contemplated — financing arrangement is undemocratic to the point of irresponsibility or that the very premises of government action in health care are fraught with logical inconsistencies and a general inability for critical self-evaluation at the policy level. Above all, my conclusion indicates that, even outside the contentious field of who pays for what, the federal-provincial partnership is an oxymoron. Each party is

1 For convenience, this *Commentary* calls this document "the Kirby report" (the chair was Michael J.L. Kirby); references herein are to volume 6 unless otherwise indicated.

2 Again for convenience, this *Commentary* cites this document as "the Romanow report" (the chair was Roy J. Romanow).

happy to repeat the other's platitudes without adding anything much of value. The most damaging consequence is a common neglect of what really happens in the trenches and what would be required to bring improvement at that level, the only one that truly matters.

The three support pillars that I propose are at once conceptually simple and high-level in the sense that they relate to macro features of the health system. They are also, *sine qua non*, conditions of success. In their absence, it does not matter how many clever conclusions are agreed to; all will fail. My pillars are:

- *A realistic plan for sharing the financial costs and risks involved in maintaining and improving health services in Canada.* At the end of the day, financial arrangements must be such that both Ottawa and the provinces feel that they are not being exploited by the other party, while adequate resources are provided to health services and other legitimate public expenditures are not jeopardized.
- *A constructive partnership between the federal and provincial governments.* Having two governments involved in the same area creates greater complexity, but partnership may offer offsetting advantages if it facilitates more rigorous policymaking with oversights, errors, and inconsistencies being detected early through constructive and uninhibited dialogue and perhaps with increased ability for concerted action across the country, with Ottawa playing the catalyst.
- *An attempt to improve performance and service quality.* The federal and provincial governments must develop a governance philosophy based on respect, support, and encouragement for health services, an atmosphere in which the natural expectation of high performance is coupled with clear objectives and a delegation of responsibility commensurate with desired accountability.

The pages that follow devote a section to each of the pillars listed above.

A Realistic Plan for Sharing the Financial Costs and Risks

Health-care spending has been increasing much faster than the national economy, creating severe pressures on governments. Confronted by intractable deficits, governments have, at times, curtailed funds allocated to health care. Because these events, albeit legitimate and inevitable, have been sudden and uncoordinated, they have led to rationing of services to the public and to variations in the funding shares of the two orders of government involved, ensuring intergovernmental tensions.

To put an end to this chaotic state of affairs, I recommend an agreed resource allocation model that would include:

- An assumption about increased future financial *requirements*, the proposed government response to such increases, and a method for dealing with unanticipated requirements in excess of assumptions.
- A rule about the way in which the requirements are to be *shared*, a rule that would cover situations in which all the risk of some requirements exceeding assumptions is borne by only one of the parties.

- A *decision* model about significant changes in program scope, giving due consideration to the partners' relative shares in meeting financial requirements and risks.

Think of any situation in which two partners find themselves involved in a common venture. Without rules covering the above contingencies, how can they avoid a falling out?

Why the Present System Flounders

Looking at the federal and provincial briefs on health care, readers have no difficulty in finding a consensus that the costs of the system will increase in both absolute dollar amounts and in relative share of gross domestic product (GDP). No one is prepared to commit to a hard figure because even a study of past trends is ambiguous since it reflects a mixture of objective factors and policy decisions about the proper level of public expenditure. Objective factors may dictate an increase in spending; however, fiscal considerations sometimes lead to suppressed demand that gets translated into rationing, such as waiting lists, whenever expectations of increased accessibility and increments in potential service levels triggered by innovation run ahead of the public resources that are actually available . However, the Kirby report quotes, with apparent approval, estimates putting the average yearly rate of increase at 1 percent above the growth of GDP (p 258).

In any situation in which two partners are involved in a common venture, without rules how can they avoid falling out?

The Romanow report, although more ambiguous, appears to agree (pp 32–34). Bear in mind that such estimates of future costs are predicated upon the maintenance of the existing provincial policies and are not meant to reflect future significant, and still hypothetical, policy changes. To be more specific, the cost forecasts are not meant to incorporate the impact of all the changes that either the Kirby or Romanow report recommend to produce the new and expanded Canadian health-care system they advocate. The money value of the natural cost increase required just to maintain the status quo can be estimated at $2.0 billion to $2.5 billion per year.[3]

The two federal briefs significantly differ in their approaches to this problem. The Kirby report's solution is embedded in a proposal to earmark half of the good and services tax (GST) as a replacement for the Canada Health and Social Transfer (CHST); this change, it estimates, would overcompensate the then-abolished CHST estimated allocations to health by $1.5 billion a year (Kirby report, 291–292). This suggestion is constructive, though being part of a controversial package of new financing options, including a national health-care sales tax or a variable national insurance premium, its viability in competition with more targeted spending for itemized programs may be in doubt. The bulk of the proposals in the two briefs that would increase federal funding deal not with that maintenance cost but with discrete changes meant to enrich the program and extend its coverage above what is presently being funded by the provinces.

3 This range is based on the stylized facts of public health expenditure that currently stands at $70 billion and a GDP growth rate of 3.0 to 3.5 percent, certainly no exaggeration!

The Kirby report (p 76) drives this point home as an argument for stricter provincial accountability: the new federal money made available for itemized expenditures — that is, equipment embodying new technology — should be payable only if the provinces can show that they would not otherwise have incurred the expenses. Never mind the bureaucratic haggling involved, the intent of restricting federal funding to incremental program enhancements is clear. Indeed, virtually none of the cost drivers the report identifies are fully reflected in the list of program enhancements. The impact of most of the enumerated cost drivers is reflected in increased per capita consumption of health services; R&D expenditures expand the service potential through innovation, in particular less-invasive diagnostic and therapeutic procedures that lead to expanded indications of appropriateness from which, *inter alia*, an expanding population of aged patients can benefit. The impact of aging alone, the Kirby report estimates at an incremental 1 percent of GDP per year (p 257).

The other important source of cost creep for simple program maintenance is derived from increased remuneration, a consequence of the fact that labour productivity in the health sector differs from that in other sectors of the economy. Yet neither brief discussed this issue except to refer it to some kind of future super health council. For example, although the acquisition and operating costs of equipment are dealt with among the itemized items, their impact on utilization is not.

The Romanow report takes a different approach to the issue of maintenance costs by virtually advocating a return to a form of aggregate cost-sharing. A federal statute would mandate increases in federal funding in step with an estimate of projected increases in total provincial health-care spending so as to reach and eventually maintain Ottawa's share of health-system funding at a set percentage, say 25 percent. However, "to avoid useless debate," the final recommendation is divorced from actual provincial costs in favour of set dollar increases, much like the present arrangement, and further emptied of meaning by contemplating a vigorous pump-priming exercise to expand the scope of the program to cover drugs and home care before the set increments kick in (Romanow report, 76).

Matching Requirements

Both federal briefs expect the provinces to carry the system's maintenance costs — in excess of $2 billion annually — with federal sharing that is merely hypothetical, but with explicit matching provincial allocations for some of the proposed program expansions. The Kirby report proposes three such programs (p 268, table 15.2):

Post-hospital home care	$550 million
Palliative care	$250 million
Community hospitals capital and equipment	$250 million

Thus, the Kirby report's cost estimates involve a total more than a billion dollars per year. The matching requirements for the provinces would, of course, be an identical amount.

In addition, the Kirby report proposes program improvements and enhancements of coverage, all supposedly entirely, or almost entirely, at federal expense (either 100 percent or 90 percent of incremental costs). But in almost all cases, these percentages refer to fixed estimates of the costs that Ottawa would consider absorbing — not necessarily to all the cost implications flowing from a federal announcement of program expansion. For instance, what the report calls the *Health Infoway* would have $2 billion allocated to it over five years, but the cost of the program is estimated at $6 billion to $10 billion.[4]

The so-called reform of primary care gets $250 million from the Kirby report, while the Romanow report is closer to the mark with $2.5 billion, though this amount refers to transition costs alone.[5] For catastrophic drug coverage (perhaps a very appropriate designation!), even the Romanow report's estimate of a matched $1 billion per year (versus the Kirby report's $0.5 billion) is likely to be hopelessly optimistic given the intent to make the *Canada Health Act*'s (CHA's) accessibility principle applicable to the drug plan and thus outlaw deductibles, coinsurance and, obviously, private insurance. Can coverage for so-called expensive drugs be effectively limited to these drugs over time? Perhaps the more appropriate question is how will *expensive* be defined over time? The public segment of Quebec's drug plan covers only 40 percent of Quebec's residents and costs some $2 billion per year (see Forget 2002 b).

The federal briefs' proposals would significantly increase costs to the provinces and raise the risks they confront.

Term Limits on Stability and Conditional Predictability

The Kirby report's proposals for expanded system coverage are subject, perhaps only because of its presentational style, to a very important caveat. Cost estimates for many incremental itemized expenditure categories are given for fixed, limited terms: five or ten years.[6] A plausible reading is that they will be wound up at the term's end. The Romanow report's approach is more suggestive of a long-term arrangement, but the long-term rate of increase contemplated only kicks in after a vigorous two-year base expansion consisting of incremental elements with high and largely unpredictable ramp-up periods to maturity. Therefore, difficulties would also be programmed in.

Taken together, the federal briefs' proposals would significantly increase costs to the provinces and even more substantially raise the risks they confront .Despite the brief writers' professed desire to provide a predictable and stable financial environment, nothing would be effectively changed from the present situation,

4 In volume 2 (Canada 2002b, 113), the report quotes approvingly a brief presented to the Senate Committee suggesting this range for the estimated cost of a Health Infostructure.

5 The Romanow report proposes spending this larger amount over two years (p 78), while the Kirby report suggests the lower amount over five years. The latter (p 85) quotes Quebec's experience with a setup cost of $750,00 apiece for family medicine groups (FMGs) to serve 10,000 to 20,000 patients. With a population of 30 million and each group serving 15,000 people, the country would need 2,000 FMGs. With a setup cost of a relatively modest $500,000, the initial cost would total $1 billion. Given 10,000 people for each group and Quebec's setup costs, the total would be some $2 billion.

6 This statement applies to a total of $1,555 million out of a total of $4,000 million in annual allocations for "expansion and restructuring" (Kirby report, 268).

even if the apparent good intentions were incorporated in a federal statute. By 2005, we will have a new Parliament and government. Suppose that, within the economic and financial context of that year, it appeared expedient to amend that piece of legislation and curtail federal financing of the system? The provinces would be not just back to square one; they would have to shoulder alone the increased burden of a swollen system. All the new federal commitments are for predetermined amounts and lack open-ended elements; all the risk that the estimates may turn out to be incorrect would remain entirely with the provinces.

The present situation can be described by the following analogy: In the Canadian health system, the provincial governments are in the position of equity holders. They manage the system and bear all the residual risks: they negotiate with unions and physicians and have to pay the consequences of unexpectedly high awards; they have to meet more-rapid-than-anticipated growth of demand or face criticism for not being able to; they confront new technologies, aging of their populations, and related issues. The federal government is in the position of a bondholder. It has a fixed financial commitment that it can reduce, even unilaterally, for reasonable cause. Ottawa long ago abandoned cost- and hence risk-sharing. The provinces have, with support from their briefs, denounced this asymmetrical arrangement; however, they have mostly underlined that Ottawa's share is no more than, say, 14 percent of total health costs. Surprisingly, they have overlooked the fact that Ottawa's portion of risk-sharing is even lower — 0 percent.

It would be inconceivable for the provinces to accept anything approaching the proposed financial plan. If they do, they will soon regret it.

With a 14 percent share of cost and a 0 percent share of risk, the federal government is a decidedly junior player. But there is more. By proposing to increase federal funding only if there is an extension in coverage for home care and drugs, Ottawa would not be increasing its share of the existing programs. Indeed, at least for some provinces not now fully committed to either extension, the change would increase their costs and, therefore, the risks inherent in any program, particularly a new and untried one. In effect, the proposals contained in the federal briefs would make Ottawa not part of the solution but part of the problem by fuelling the flames of rising expectations. Taking on the goal of doing everything for everyone constitutes a rhetorical ego trip if another jurisdiction pays 85 percent of the cost and assumes all the risks of erroneous or over-optimistic planning.

The federal briefs have little to offer that is truly constructive. This is not to say that they offer nothing. They recognize that the present financing arrangements are not viable and identify several gaps in the program, but the recommended solutions leave much to be desired. Several alternative arrangements should have been discussed and compared.

The briefs underplay the importance — in terms of costs and financial risks — of maintaining the system as it is. Instead, they scramble forward to propose expansion, grabbing decisionmaking authority that is not commensurate with the limited federal commitment, which is neither stable nor, in the medium term, predictable. The asymmetry envisaged, with one partner paying and the other making the important decisions, would aggravate the democratic deficit inherent in the present arrangements. It would be inconceivable for the provinces to accept anything approaching the proposed financial plan. If they did, they would soon regret it.

A Constructive Federal-Provincial Partnership

Even if the resource and risk allocation of the federal briefs' proposals could be resolved successfully, questions about the respective roles of the two partners and the quality of their interaction would remain. At present, neither partner has much respect for the role of the other. The federal government is likely to berate the provinces by saying that their only concern is to get more money from Ottawa, and the provinces are apt to believe that the federal government's only concern is to score political points at minimum cost. This cynicism has some foundation if only because the two briefs give no indication that their writers have given any serious thought to the matter.[7] In addition, there are indications of misconceptions about both parties' roles.

The federal government pictures itself as the guardian of the CHA's five principles, sometimes elevated to the even higher status of fundamental values. The provinces pay lip service to those principles although many have informally broken one or the other, largely at no cost to themselves and to Ottawa's indifference (see Canada 2000). The briefs fail to scrutinize the adequacy of the principles and even suggest additions to the present list.[8] Strangely, the official list omits an equally important principle that, in effect, takes precedence over all the others: namely, that the health system has to live within government-imposed financial constraints. This restraint is a facet of the single-payer characteristic of the Canadian system, a characteristic embedded in the public-administration principle and reinforced by the prohibition of user charges inserted in the 1984 CHA.

One could define a legitimate role for the federal government if it could find the courage to specify a mission based on a smaller set of principles that are logically consistent.

Taken together, the existing principles constitute an internally inconsistent set. One cannot at the same time guarantee to provide comprehensive services to all (universality) and live within the budget, except by coincidence at a moment in time. Each of the elements — the population and its needs, the list of potential services, and the availability of financial resources — moves according to its own dynamic. From time to time, something has to give way, and the system be allowed implicitly to find its own equilibrium through rationing. Logic demands that one of the principles be relaxed. I argue elsewhere (Forget 2002a) that the comprehensiveness principle provides the weakest link in this iron triangle.

This situation of inconsistency in a large system, which is not infrequent, is called *overdetermination*. In a well-meaning intent to plug all deficiencies in such a system, it is tempting to list all the must-do conditions for improvement and in doing so to defy the laws of logic. The result is a set of recommendations so constraining that no feasible configuration can satisfy all the conditions simultaneously. This situation is one of the things that ails the Canadian health system today.[9]

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7 Neither of the two federal briefs contains a single chapter or even a substantial section on the role of the provinces.

8 The Kirby report recommends a "Health Care Guarantee" (pp 97–122) and at least implicitly recommends, as does the Romanow report, the addition of an accountability principle.

9 The Mazankowski report (Alberta 2001) issues a strong wake-up call by recommending that an expert panel be struck to define more narrowly the scope of insured services in that province. The Clair report (Quebec 2001) expressed a similar concern.

The federal government has received no help from the authors of its briefs in this regard. One could define a legitimate role for the federal government, despite its low level of financial and risk-sharing, if it could find the courage needed to specify for itself a mission based on a smaller set of principles that were logically consistent. A national health-care system that conformed to the single-payer model and to universality (portability is a mere corollary to universality) would do very well provided that it was defined around a *core of services* and that everyone recognized that this core itself was contingent on the funding made available. In the past, *national* has always meant *expanded services*, and this association explains the rather meaningless findings of the national consultation conducted for the Romanow Commission.[10] The correlation between funding and the scope of the nationally insured core is what could ensure genuine credibility with regard to Ottawa's commitment to the system; with reduced funding, the nationally guaranteed core would have to shrink. I expect that the provinces would take seriously a federal mission defined in this way.

Ottawa's lack of consistency and realism with regard to the several principles it champions is fully matched by the provinces' mishandling of their most important role with regard to health: personnel management and planning. The provinces perform three important functions in this regard — training health-care personnel, regulating the professions, and collective bargaining — functions that cannot be considered in isolation from one another, though I separate them for convenience.

Ottawa's lack of consistency is fully matched by the provinces' mishandling of their most important roles: personnel management and planning.

Training

Most of health-care personnel are specialized workers who have little opportunity to find employment outside the health-care sector. Consequently, forecasting errors, the lowering of ceilings on training places for short-term financial reasons, and programs of accelerated retirement may later create serious shortages that are difficult to fill since the health sector cannot in practice draw upon similarly trained personnel outside the area. To put the point another way, mistakes in planning create such serious risks that public policy should perhaps aim for a surplus.

Issues of motivation enter when training places remain vacant or when social change modifies the equation confronting potential applicants. The question of how many nurses and doctors Canada needs cannot be divorced from issues of service quality. Contact with sick people requires, quite apart from all the technical wizardry, the availability of trusted professionals to provide care and also to help patients understand and interpret what is going on and what to expect, to coordinate an increasingly complex series of discrete interventions and to ensure truly informed consent. Numbers need to increase, as well, to augment the professionals' own quality of life, ensuring recruitment and retention.

10 See, for example, Maxwell, Jacobson, and Legowski (2002). The main "finding" of this report on the Romanow consultation is that Canadians are willing to put up more money into the health system but only if doing so will improve it. But what is the alternative? More money to make it worse? Or no money, even if it could be improved? More money to ensure its maintenance did not figure.

Federal briefs tend to see here only a question of inadequate numbers on the basis of historical and international statistics.[11] To this they add vague references to increasing productivity with no thought for service quality and suggest that enlarging the scope of responsibilities of nurses could be a solution, whereas they already are in short supply. The recommended increase for a specific number of training places (funded at the current level of costs) would continue for ten years, whether appropriate or not.

Regulation of the Professions

The health field includes some 20 regulated professions. This universal system is closely associated with the pursuit of quality in health care as the life sciences and associated technologies have become more complex. Indeed it is because of those well-defined roles that we can talk of a health-care team. Moreover, the definitions embedded in regulated roles reflect global influences that have shaped each role around the world. For physicians, for nurses, and for other health workers, these definitions are passports that allow them mobility because in practice the roles are nearly interchangeable between Canada and the United States, Europe, China or Chile.

These definitions also create monopolies for each task and the danger of professionals' capturing of the system. This issue is to be addressed by other elements of manpower policy and planning, but suggesting that these roles could be altered in a top-down process and that professionals be trained to work better in teams is hardly designed to improve their table manners. In this regard, the Romanow report (p 118) verges on irresponsibility by suggesting mandatory changes. Alterations must be consensual and more or less in step with international trends.

Collective Bargaining

Give the leaders of a union that enjoys a legal monopoly and operates in a context of labour scarcity a mandate to negotiate with the deepest-pocketed employer imaginable and you have a perfect opportunity for confrontations and outcomes against the public interest and for private gain. The costs will be not only monetary; they will be found in a whole series of contractual, legislated, or customary arrangements that give employees and physicians the status of owners of elements of the system. This is what has happened in the Canadian health-care system. In this sense, it has already been privatized, except that the shift has taken place without compensation.

Provincial policy with regard to personnel management and planning seems to have worked in reverse. The system has often failed to see that abundant supplies of well-trained professionals, beyond their contributions to better service quality and improving working conditions, would help to loosen corporatist tendencies.

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11 The Kirby report (pp. 185–200) and the Romanow report (pp. 99–126) seem to arrive at different conclusions about the numbers themselves, with the former insisting on the need to increase the supply of physicians and nurses and the second dwelling on inequalities in deployment.

Compounding the problem, provinces have espoused the centralized collective bargaining option, placing themselves in the weakest possible negotiating position.

Never is the federal government more respectful of provincial jurisdictions than when it comes to collective bargaining. The federal briefs contain not a word on the subject.

Overall

Just as Ottawa is plagued by its own iron triangle of universality, comprehensiveness, and treasury supremacy, the provinces have to live with training, regulation, and collective bargaining. Each party, federal and provincial, has to make difficult choices that have so far been eluded, and neither gets any help from its partner.

In both cases, one can imagine a partner's greater distance from day-to-day concerns and wider perspective might be helpful if used constructively. Yet what we have instead is either polite silence or recommendations that issue from a blinkered vision so that no value is added. In effect, the partnership model for the simultaneous presence of the federal and provincial governments in health care is perhaps overly ambitious. Note that this failure to constructively interconnect is costly because it deprives Canadians of the benefits that concerted action could produce. For example, substantial changes in personnel planning and management probably cannot be achieved successfully by one province acting alone, but could be realized in a concerted move with the federal government acting as the catalyst.

Not only do the briefs propose a financial plan that does not make sense, it would deepen the democratic deficit of the current arrangement.

The briefs often use the word *accountability* as if the problem of Canadian health care were analogous to the ENRON scandal in the United States; better accounting and more disclosure would save the system. This attitude in the briefs' analysis is a fundamental flaw. The more likely source of difficulty is *not* that funds have been misappropriated or that wanton waste and profligacy exists. Rather, the problem to a substantial extent is rooted in bad policies. Not only do the briefs propose a financial plan that does not make sense and would only deepen the democratic deficit of the current arrangement. Worse, the essential roles assumed by the two levels of government are logically or strategically flawed. Unless governments are held directly accountable for their own macro-level mistakes, further attempts to cast the blame and hold to account care providers threaten ruin to the entire edifice. The federal-provincial partnership model has never worked in the past to produce significantly better policymaking, at least on substantial issues, and nothing in the briefs leads one to hope for better performance in the future. Therefore, the time has perhaps come to question the need to maintain this sterile duality in governance. Bad policy that is clearly the responsibility of a single government would, one hopes, be more easily detected and corrected.

An Approach to Improving Performance and Service Quality

Hospitals existed for centuries before any country had a national health system. Governments did not invent health care. They simply decided to pay for it, and ever since they have been trying to manage it. Perhaps their singular lack of

success would improve if they based their actions on a better understanding of the strengths, the incentive structure, and the organizational culture of hospitals and other community-based health-care providers. Yet in this regard the federal briefs are content to echo widespread misconceptions within provincial health ministries, which view health-care organizations as planners' putty, an infinitely malleable mass of activities and people.

Community-based health-care providers are grounded in one of the fundamental traits of human nature: a desire for cooperation and mutual help in certain aspects of life, with health-care in the foremost position. This kind of assertion used to be met with scornful sneers until a Nobel laureate economist managed to demonstrate the reality of this departure from classical rationality.[12] Can the civil service or a company count on the spontaneous cooperation and devotion of volunteers the way most hospitals and community institutions can? Can they raise funds from the public in the same manner? Canadian physicians were less than ecstatic when medicare was introduced 30-odd years ago, at least if one is to judge from the positions officially taken by organized medicine. But they now identify remarkably closely with the nonprofit system in which they work, seeing it as very much in line with the values their profession has traditionally held in high esteem. Even in the United States, where enthusiasm for the private, for-profit operation of everything approaches the intensity of a religious value, fewer than 20 percent of hospital beds are operated in a for-profit setting. And for-profit health-care institutions have underperformed the stock market and bankruptcies have been frequent. Health care is different. (See Kuttner 1999.)

When government wants to manage health services, it enters the world of unintended consequences. Frustrations pile up, but knowledge does not accumulate.

Health-care providers — particularly, though nor exclusively, hospitals — are institutions in the sense that they are organizations not only set up as a response to external opportunities and pressures and designed to minimize transaction costs, but are internally driven as well.[13] These internal forces take the form of internally developed standards and norms of behaviour and also individual goals set by professionals driven by a sense of who they want to be and what role they want to play. The outcome is a structure of incentives that drives behaviour with personal goals, peer standards, and finally externally determined norms (in that order of importance).

Consequently, when government wants to manage health services, it enters the world of unintended consequences. Frustrations pile up, but knowledge, unfortunately, does not accumulate. Another health minister or a new government brings another theory of management to bear, and the cycle repeats itself. This result is not just irritating for governments; year after year of apprentice-sorcerers being let loose on health providers is bound to affect the morale, efficiency, and recruitment of those who staff and immediately manage front-line services. Yet if performance is to be improved and service quality is to receive increased focus, the front line — and nowhere else — is where change must come. Ways have to be

12 See for instance Jolls, Sunstein, and Thaler (2000). The reference to the Nobel laureate is to Daniel Kahneman, another of the authors in the same collection of papers.

13 This comment draws on the insight provided by Michel Foucauld's 1965 analysis of hospitals and other "closed" communities. MacFarlane and Prado (2002) develops this approach and applies it to the Canadian health-care system.

found to give these concerns the enhanced saliency they deserve as part of the internalized values of front-line care givers and front-line managers. This effort might not be difficult if those concerns were clearly spelled out (they never have been in the past except as afterthoughts) and, more important, if efforts were made to empower health-care providers. This would require a kind of unilateral disarmament from ministries of health.

The Kirby report provides an excellent example of what could be done by encouraging the adoption of payment by result (pp 25–62). Canada is almost alone among western countries in not having put in place a financing system based on the American concept of diagnosis related group (DRG). Quebec has received similar encouragement from the Clair report (Quebec 2001)[14] but has not yet acted on it. The value of the Kirby report's proposal is, however, much mitigated by its recommendation of creating several separate funding programs for which distinct qualifying conditions and separate authorization channels would apply.[15] The Kafkaesque situation thereby created for front-line managers would be so serious that the best advice would be for the most dynamic and entrepreneurial of them to leave the field to those with strong bureaucratic abilities.

The onus is on governments to persuade us that they are able to do the job; neither of the briefs seems to realize where the true burden of proof lies.

To be clear, a policy of genuine subsidiarity — entrusting significant responsibility and the corresponding authority to front-line institutions to improve performance in resource utilization and enhance well-defined service quality objectives — is an option that none of the federal briefs seriously considers, following in the footsteps of previous provincial briefs. Subsidiarity requires governments to sincerely admit their inability and inappropriateness as managers of health services, whether directly or through surrogates such regional offices or councils. Unfortunately, the writers of federal and provincial briefs, although working in the interests of the people, find taking a critical view of governments impossible. Oblivious to the fact that many of the problems of health care have arisen out of blunders, inconsistencies, oversight, and uncritical self-confidence from governments, the brief-writers' recommendations suppose a still heavier dose of government. In contrast, setting mutually consistent program and financial guidelines and establishing the broad context of personnel policies would be more than enough and would imply quite a stretch from past performance if done well. At present, the onus is on governments to argue persuasively that they are able to do the job: none of the briefs seems to realize or accept where the true burden of proof lies.

Empowered front-line institutions should earn revenue in proportion to their performance and sufficient to offset depreciation on their facilities and equipment and to gain the freedom to actively manage replacements and enhancements. This is the surest way to depoliticize health care.[16] Capital investment is a tool of

14 The Clair report (p 161) contains a very general indication about the desired direction. It is, however, fully fleshed out in the subsequent Bédard report (Québec 2002).

15 The Kirby report (p 268) envisages no fewer than 16 different funds for itemized expenditure items with which health-care providers might have to interact.

16 This phrase implies that DRG rates be set not only to reflect current operating costs but also the costs inherent in using up facilities and equipment that are no less real than salary and current supplies.

management and a power that can be used locally to ease in changes and ensure compliance with corporate goals. It should no longer be denied to managers. Neither should the real cost of depreciating assets continue to be withheld from the total program cost of services leading to a distorted, truncated view, biased in favour of short-term considerations. Front-line managers should also acquire the freedom to contract with their personnel, as well as the freedom to subcontract. Following the Mazankowski report,[17] the Kirby report (pp 317–319) wisely supports this widening of managers' mandates.

Some analysts have made suggestions that take into account the cultural gap between government and health providers and a widespread feeling that health care should be depoliticized. The Kirby report reviews five different authors who seek to establish some kind of independent evaluator of the performance of the health system and, in some cases, to act as a referee between the federal and provincial governments and to initiate (and fund?) innovative proposals. The Kirby report (pp 11–17) then recommends a national health-care council with the mandate to evaluate aspects of the health services and make funding recommendations to the federal government. The Romanow report offers dramatically more ambitious ideas for a Canadian health council; it would, in effect, do almost all that provincial health ministries do.

Whether it is Kirby's or Romanow's version of the council that the federal government espouses, what finds favour with federal policymakers is a superstructure of statistics gazers and Gossplan-type bureaucrats. Curiously, when operating far from home, most western governments have by now understood that in the presence of cultural differences, effectiveness calls for different approaches; rather than operate through civil servants, these countries now use nongovernmental organizations (NGOs). Could they not think of hospitals as domestic NGOs?

Finally there is the question of the Health Infoway. Information technology is a good servant but a bad master. And the briefs, by presenting it as a tool for supervision, control, and evaluation from above, strongly suggest that it would play the role of master in the health system. The heavy insistence on national uniformity clearly indicates that, far from being conceived as a friendly tool for better local performance and service quality and hence an empowering development for caregivers and front-line managers, this technology would have as its chief selling point to government the potential for fingering delinquents. The best comment on this attitude is found in a study of the federal penitential system.

> Coming out of a 'sixties mentality, there was a sort of belief out there that people can make a difference and when you work with people, be it in the health system, any kind of system where you are working with people, then you believe that an individual professional could make a difference. [But with the introduction of the computerized Offender Management System] it is more and more case management by numbers. We are attached to those computers. It is almost like as

17 When Mazankowski first made this recommendation, he was bitterly attacked as proposing something that contradicted the public administration principle of the CHA. This attack was legally unjustified criticism; it was also unwise from a policy perspective.

long we feed that machine and keep it happy then we are okay. We have done our job. (Jackson 2002, 94.)

Summary and Conclusions

One of the so-called basic principles of the Canadian health-care system is public administration. Until recently not much thought has been given to it. The requirement was originally intended as an exclusionary principle to keep private insurers at bay. Later, it was extended, through the accessibility principle, to also outlaw contributions from users. The single-payer system that resulted from these exclusions wanted neither competition nor even any indicator of its own flagging performance. Who can be surprised that this radical exclusion of other sources of financing has recently attracted calls for its relaxation?

Yet since the single payer — in other words, government — has had the entire field to itself, it has not shown much aptitude for introspection. First, it failed to notice its own schizophrenic nature: a single payer yes, in the sense that the taxpayer is the ultimate resting point, but acting through two increasingly estranged partners, the federal government and its provincial counterparts. Because the primary responsibility of the single payer is *to pay for promised services*, this payment function appears to require a well-coordinated approach between the federal and the provincial treasuries. But the present situation reflects a serious mismatch between the two partners and something close to divorce if the proposals contained in the federal briefs are adopted. Major decisions about expanded commitments simply cannot responsibly be taken by the junior partner. In the present real-life situation of health-care financing in Canada, the junior partner is the federal government with a less-than-20-percent share of costs and no element of risk, all its contributions being in fixed and unilaterally modifiable amounts. The federal government has no equity in the system, present or proposed. The current proposals, made in the name of greater accountability, must rate as some of the strangest aberrations in public policy pronouncements.

Why are the briefs so reluctant to look at the broad picture? Where is the vision?

Financial issues aside, the assumed partners have shown, over a period of several decades, no inclination to behave as partners. Rather, each has treated what the other has done with neglect verging on scorn. Truly committed partners working seriously for a common cause would, of course, be expected to challenge one another when one observed oversight, inconsistency, or plain error that threatened to disturb, hinder, or even void the common efforts. The provinces have been at times seriously annoyed at the implications of some of the principles proclaimed by Ottawa, but they largely went their own way while mouthing pleasantries at federal-provincial meetings. The federal briefs deplore and propose to correct the inadequate supplies of trained personnel several years after they have become public knowledge and have begun to be addressed.

Even with the benefit of distance and hindsight, why are the briefs blind to the need to look at the broad picture where service quality, personnel motivation, numbers adequacy and collective bargaining interact? Where are the abilities within these vast bureaucracies, federal and provincial, for self-assessment and sensible planning? Where is the vision? Where in the briefs prepared for the

federal government is the broader context to give meaning and perspective — or show their absence — to the shopping-list approach. Why is everyone talking about a system when it is nowhere apparent in the recommendations? Should reform not start with a systematic approach to government's own governance of health care? Governments talk about evidence-based medicine and health care. This is a fine concept, very much a work in progress, but what about evidence-based government?

Of course, acting wisely is not much fun; it is much more enjoyable to lord it over others. There is virtually nothing good to show from the innumerable reforms of the health services in one province after another. This organigram mania, typical of command-and-control systems the world over, is less management of health services than management of politicians' perceptions of health services.

Although the provinces have especially cultivated this particular folly, how disheartening to see it emulated in the federal briefs. Politicians and civil servants, uninspired to understand the incentive structure at work in the health field (so different from their own incentive structure), have made the ultimate goal of reform proposals to, in effect, transform the Canadian health system into something that looks, behaves, and responds to its master as other branches of public administration do. The several exhortations to depoliticize health care are set aside as premature. Accountability gets in the way of taking the only sensible course, which is to delegate and empower health-care providers; maybe when everyone is busy serving the monster of a gigantic Health Infoway and we have statistics on everything, it might be looked at again.

Can we find in the federal briefs a workable plan for sharing financial costs and risks? No.

This *Commentary* started by setting out three pillars that support three simple but pregnant questions. Can we find in the federal briefs the outline of a workable, responsible plan for sharing the financial costs and financial risks involved in maintaining and improving the Canadian health-care system? The lack of symmetry in the proposed arrangements compels me to answer in the negative. Second, are there proposals that could lead to a constructive partnership between Ottawa and the provinces because each party would be challenged to think through its actions and could benefit from its partner's input? Here again, I find no reason to expect improvement over the miserable record of the past. Finally, do the recommendations reflect a deep understanding of how a search for excellence in the delivery of health services could be nourished and encouraged? Again, a negative conclusion sadly imposes itself.

Many Canadians have laboured over the gestation of these briefs, not least the honourable, dedicated, and knowledgeable members of the Senate committee, the two chairs, and their staffs. In spite of the efforts made to consult widely, I doubt anyone who was involved in either of the two processes could really address any more than a small issue at a time, leading to a mosaic picture of the problems of health care in Canada. But in such a system, everything depends on everything else, and the absence of unifying themes becomes apparent only when the recommendations can be seen as a whole. Now that this point has been reached, one hopes that sober second thought will take place, albeit informally.

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